Terms of Therapy, Waiver of Liability and Confidentiality

Client's Name: _____ Contact no: _____

Email Address: _____ Date: _____

The person requesting help must please read and sign the Waiver of Liability and Waiver of Confidentiality

_____

Initials

Waiver of Liability

The Client acknowledges the following regarding Dr. van den Berg and the Therapy sessions:

1. This Therapy entails the Socio Cognitive Neuroscience Approach of which the areas of analysis include: The Social level, including both motivational and social factors; the cognitive level, focusing on information processing mechanisms influencing social-level phenomena and the neural level, concerned with the brain mechanisms underlying cognitive-level processes, therefore the health and diet of the Client is also of concern. The therapy is however based on prayer and applied through Prayer Ministry where applicable.
2. The faith and conviction of the Therapist is in the Creator of this Universe: The God of Israel and in His Son, Jesus through the dynamic working of His Holy Spirit.
3. I understand that I will commit to assist my own level of therapy by embracing and following through what has been discussed during the session. By complying to the expectations set during therapy and supplying my full cooperation and consent.
4. I understand that I hold the right to discontinue therapy whenever I am convinced that it is not aiding my process toward wholeness any longer.
5. I understand that if I need to cancel the appointment for any reason, I have to let Dr. van den Berg know no later than 12 hours prior to the set date and time. If the appointment is on a Monday, the Friday before will be viewed as the day before, so as to give someone else the opportunity to take the appointment. If not, the session must be paid in full.
6. I understand that it will be up to the Therapist's discretion to accommodate late cancellations. If I do not cancel the session at all, (including forgetting about the session) I am responsible for the full payment.
7. I understand that all payments of single or bundle sessions must be made in full prior to the date and the proof of payment sent to the mail address as in the signature below. If this is not done, Dr van den Berg holds the right to refuse therapy.

082 451 6928

gerdi@heartmatters.co.za
heartmatters.co.za

26 Everglen Manor
Eversdal Road
Durbanville

8. I understand that the therapy sessions are strictly during times of appointments. I may, however, stay in contact between sessions via e-mail and WhatsApp's with Dr. van den Berg. I will respect her privacy and will not come to the Practice outside of therapy 's scheduled times.
9. I understand that Dr. van den Berg is making no guarantees about the success of the therapy process.
10. I understand that this is not traditional therapy and waive any right to hold Dr. van den Berg legally liable for the results of this therapy process.

_____

Initials

Waiver of Confidentiality

Dr. van den Berg may discuss details of the therapy sessions with involved other when it is discerned that either the Client's life or someone else's is in danger. Otherwise with consent, when seeking added assistance in order to aid the Client's growth toward wholeness. She may then discuss the sessions and forms (where applicable) with the referred specialists, e.g. Dietitian, Medical Practitioner, Psychiatrist or other Therapist.

_____

Client's signature

The Client acknowledges the following by his or her signature:

1. I may be referred to other sources of Therapy, counseling or support.
2. That all statements made are confidential, including all written information and that legally and ethically these may not be disclosed without written consent, except in the above specified concessions.
3. I have read the Terms of Therapy, Waiver of Liability and Waiver of Confidentiality.

_____

Client's signature